

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7918	(X2) MULTIPLE CONSTRUCTION A. BUILDING 77 - BUILDING 77 B. WING _____		(X3) DATE SURVEY COMPLETED C 10/28/2011
NAME OF PROVIDER OR SUPPLIER PARKWAY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PARKWAY WEST MEMPHIS, TN 38109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: Intakes: TN00028838</p> <p>During the self-report investigation on 10/28/11, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-8, Standards for Nursing Homes.</p>	N 002			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

STJL21

If continuation sheet 1 of 1